BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KELLY ANN MIYASATO 2008 Pullman Lane Apt #3 Redondo Beach, CA 90278 Registered Nurse License No. 575084 Respondent.	Case No. 2004-286 OAH No. L-2004060246

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on May 25, 2006.

IT IS SO ORDERED April 25, 2006.

LaFrancine W Tate

Vice-President
Board of Registered Nursing
Department of Consumer Affairs
State of California

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	**Case No. 2004-286**
KELLY ANN MIYASATO ***4404 Camero Avenue*** **Los Angeles, CA 90027**	**OAH No. L-2004060246**
Registered Nursing License No. 575084	
Respondent.	

PROPOSED DECISION

This matter was heard by Christine C. McCall, Administrative Law Judge with the Office of Administrative Hearings, on February 6 and 7, 2006, in Los Angeles, California. Complainant was represented by Linda Sun, Deputy Attorney General. Respondent Kelly Ann Miyasato was present and was represented by Phyllis M. Gallagher, Attorney at Law.

Oral and documentary evidence were received and argument was heard. The record was held open until March 2, 2006, to allow Complainant to submit additional evidence regarding the costs of investigation, and to permit Respondent to object, to proffer supplemental and/or rebuttal evidence, or to otherwise respond. Complainant timely submitted a Certification of Costs: Supplemental Declaration of Linda L. Sun, Deputy Attorney General, which was marked as Complainant's Exhibit 10. Respondent made no objection or other response, and Complainant's Exhibit 10 was admitted in evidence. On March 2, the record was closed and the matter was submitted for decision.

FACTUAL FINDINGS

1. On April 9, 2004, Complainant Ruth Ann Terry, M.P.H., R.N., filed the Accusation while acting in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs, State of California. On January 24, 2005, Complainant filed the First Supplemental Accusation, also while acting in her official capacity.

2. On December 14, 2000, the Board issued Registered Nursing License No. 575084 to Respondent. That license is in full force and effect and will expire on December 31, 2006, unless renewed.

3. By Joint Stipulation, executed on behalf of Complainant on December 13, 2005, and by Respondent on December 15, 2005, the parties stipulated to the truth of each and every allegation contained in the Accusation and the First Supplemental Accusation. Further, the parties stipulated that the facts as alleged in the Accusation and the First Supplemental Accusation constitute a basis for discipline of Respondent's license.

4. As provided by the Joint Stipulation, Respondent presented evidence as to mitigation and the parties offered argument as to the appropriate penalty.

Respondent's Conviction and Underlying Facts

5. As set forth in paragraphs 26a, b and c of the First Supplemental Accusation:

a. On November 1, 2004, Respondent was convicted by the court on her plea of nolo contendere to violating Business and Professions Code section 2052, subdivision (a) (practicing medicine without a certificate - a felony), in the Superior Court of the State of California, County of Los Angeles, Northeast Judicial District, case number GA054672, entitled *The People of the State of California v. Kelly Ann Miyasato.*

b. The circumstances surrounding the conviction are that on or about June 7, 2003, Respondent injected the drug Diprivan into a patient by way of an intravenous push (IVP) through the patient's heparin lock without a physician's knowledge or order, as set forth more fully in paragraphs 14 through 16 of Accusation No. 2004-287. Hospital policies and procedures allow Diprivan IVP to be administered only by a physician to an intubated or mechanically ventilated patient. The patient was neither intubated nor mechanically ventilated and died as a result of Respondent's actions.

c. Respondent's sentence includes five (5) years' [sic] formal probation, $200 in restitution, 350 hours of community service and a total fine of $2700.00.

6. Respondent is also required by the terms of her sentence to pay the costs of her probation in the amount of $50 per month.

7. Additional stipulated facts and circumstances underlying Respondent's conviction, as set forth in the Accusation, paragraphs 14 and 15 are these:

> 14. On May 20, 2003, an 80-year-old patient (Patient P.A.[1]) was admitted to Providence Saint Joseph's Medical Center, Burbank, California, complaining of worsening weakness, weight loss and poor appetite. On June 4, 2003, a bone marrow biopsy revealed multiple Myeloma. Due to the patient's additional health problems, age and extent of plasma cells in his bone marrow, no treatment was given for the Myeloma. Accordingly, the family desired no aggressive treatment options and a "No Code Blue," which meant in the event the patient has a cardio-pulmonary arrest, no aggressive resuscitative measures should be initiated.
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> 15. From on about [sic] June 6, 2003 to June 7, 2003, while working a 12-hour shift from 1900 hours to 0700 hours, Respondent was assigned to care for Patient P.A. in the ICU [Intensive Care Unit] at Providence-Saint Joseph's Medical Center. At about 1900 hours, Respondent reported that Patient P.A. was awake, alert and restless with stable vital signs and oxygen saturation. According to the day shift nurse's notes, she indicated that Patient P.A.'s level of consciousness and behavior varied from awake, agitated, confused and combative to sleeping. Respondent documented a similar assessment from 1900 hours to 0100 hours. At about 0100 hours, Respondent medicated Patient P.A. with the physician-ordered Risperdal 1 mg tablet for agitation. When Patient P.A. Continued to be agitated, Respondent asked a co-worker, Amy Brunner, RN, if there was a drug available to be given to Patient P.A.for agitation. RN Brunner stated there were two patients in the ICU who were receiving Diprivan. RN Brunner then went and withdrew approximately 4 to 5 ccs of Diprivan into a syringe from another nurse's patient's running intravenous (IV) tube and left it for RN Miyasato to be administered intravenous push (IVP) to Patient P.A. At about 0205 hours, Respondent took the Diprivan and injected approximately 4 ccs Intravenous Push (IVP)[2]

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[1] In the interest of the privacy of the deceased and his family, the patient's initials are used throughout in place of his name.

through Patient P.A.'s heparin lock. Patient P.A. was not intubated or ventilated before or after the Diprivan administration. There was no physician's order for Diprivan for Patient P.A. Immediately after the Diprivan administration, Patient P.A.'s oxygen saturation and heart rate started to deteriorate. Respondent asked for help and in an attempt to reverse the effects of Diprivan, she gave Patient P.A. oxygen, Narcan IV and Epinephrine IV. Patient P.A. was pronounced dead at 0215 hours on June 7, 2003.

8. *Additional facts and circumstances underlying Respondent's conviction, not part* of the Joint Stipulation, were established by the evidence as set forth below in Factual Findings 9 through 19.

9. Throughout the first six hours of Respondent's shift on June 6-7, 2003, Patient P.A. was agitated and physically restless. He attempted to disturb his nasal tubes, notwithstanding that mitten restraints had been placed on his hands during the previous shift. He repeatedly put his arms and legs through the bedrails in unsuccessful attempts to get out of the bed. He was non-responsive to Respondent's instructions and to her other efforts at amelioration including hand-holding, music, television and changes in the lighting. His agitation did not abate or improve after Respondent administered the medication ordered for that purpose by the physician. Although Respondent believed that Patient P.A.was in pain, she became frustrated with him and his needs at times over the course of the night.

10. Respondent did not call the attending physician to report the extent and degree of Patient P.A.'s agitation because she feared that the physician would yell at her and instruct her that his agitation was her problem to handle. Respondent had never previously experienced anger or rudeness from the doctor in charge of Patient P.A., but in the past she had experienced other physicians' anger or belligerence when she contacted them late at night about patients' conditions.

11. Although Respondent is familiar with Valium and Ativan, which are often prescribed for agitation, anxiety and sleeplessness, Respondent claims that she did not administer either of those to Patient P.A. because there were no doctor's orders for those medications. Her purported reason for not administering the sleep-inducing drugs is not credible because Respondent did administer Diprivan, with which she was not familiar, even though there were no such orders. Respondent chose to administer Diprivan to Patient P.A. because it was easily accessible and not easily traced to Respondent. Valium and Ativan were stored under lock, and Respondent could not have accessed either of those medications

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[2] The 4ccs of Diprivan IVP would be equivalent to 40 mg of Diprivan, which is the general anesthesia induction dose. Patients receiving this dose would require assistance in maintaining a patent airway and positive ventilation.

without being discovered. Diprivan, on the other hand, was immediately accessible because another patient close at hand was receiving it intravenously at that same time.

12. At the time that Respondent administered the Diprivan to Patient P.A., Respondent had not exhausted the variety of mechanical or external restraints that were available to her to address Patient P.A.'s agitation and restlessness.

13. At the time that Respondent administered the Diprivan to Patient P.A., she did not intend to record in the patient's chart the use of that drug, and did not do so until after the patient died when she was instructed by a supervisor to chart the time, dosage, method, circumstances and results of her use of the Diprivan.

14. Within minutes after the death of Patient P.A., Respondent removed the intravenous and nasal tubes from his body, and put them and the Diprivan syringe she had used in a bag which she carried to the trash. Further, Respondent retrieved from the glass rubbish a discarded bottle of Diprivan, which had been partially emptied for another patient, and placed this bottle in the bag with the tubes and syringe. Respondent also cleaned the body of Patient P.A. All of these actions were completed before the arrival of the police and all were contrary to the policies, procedures and protocols established for deaths not of natural causes, which must be examined by the Los Angeles County Coroner. Respondent testified that these actions were routine and that, because she had no previous experience with deaths under the coroner's jurisdiction, she was unfamiliar with the need and special rule to leave the scene and body untouched in those circumstances. This testimony is not believable in light of the extent and degree of Respondent's training, education and clinical work experience as a Registered Nurse. To the contrary, Respondent's actions in the minutes immediately after the death of Patient P.A. demonstrate consciousness of guilt and an intentional effort to evade discovery of and responsibility for her actions.

15. When first questioned about the source of the Diprivan, she administered to Patient P.A., Respondent lied to the hospital's risk manager, the attending physician and the nursing supervisor, falsely stating that she had used a new bottle of Diprivan. Respondent claims that her purpose in this lie was to take all of the blame for the patient's death and to protect other nurses who assisted her and had actual knowledge of her actions.

16. Respondent refused to accept full responsibility for Patient P.A.'s death. Respondent admits that by administering Diprivan to Patient P.A. she hastened his death by a few days, but Respondent contends that a number of co-morbidities contributed to his death.

17. Approximately three weeks after her crime, Respondent began employment as a "contract" nurse, working temporary assignments in hospitals throughout the county for two nursing outsource agencies. Respondent did not disclose the matter of Patient P.A.'s death or the pending criminal investigation to either agency, nor to any of the hospitals in which she worked. Respondent told the two agencies only that she had made a "medication error" in her prior employment.

18. Respondent is presently employed by Gerber Ambulance Co. She has worked there as a nurse-coordinator for nurse transport and paramedics since October of 2003. Respondent did not disclose to Gerber the potential discipline of her license, or the fact that she was facing criminal prosecution for the death of a patient, until she had been employed there for approximately a year. At that time, prompted by news coverage of her criminal case in which her picture was broadcast on television, Respondent advised her employer of the criminal charges then pending against her.

19. R. N. Peggy Kalowes, Complainant's expert witness in nursing issues for more than fifteen years, with special expertise in end-of-life treatment, reviewed all documents pertaining to Respondent's care of Patient P.A. In the opinion of R. N. Kalowes, Respondent is not presently competent to safely practice nursing. Kalowes testified that Respondent does not understand or appreciate the scope of nursing, and lacks understanding of her responsibilities for patient care. Also, in Kalowes' expert opinion, Respondent lacks critical thinking ability, basic nursing knowledge, professional judgment, compassion, honesty and common sense. Kalowes opined that Respondent is a grave risk if allowed to practice nursing on probation. Kalowes' testimony and opinions were credible and persuasive.

Causes for Discipline

20. The stipulated causes for discipline, set forth in paragraphs 16, 17, 18, 19 and 20 of the Accusation and paragraph 26 of the First Supplemental Accusation, are as follows:

> 16. Respondent is subject to disciplinary action pursuant to section 2761(a)(1) of the Code and in conjunction with Code of Regulations, title 16, section 1442 in that on and between June 6, 2003, to June 7, 2003, she was grossly negligent as follows:
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> a. On June 6, 2003 at about 2000 hours, 2200 hours and 2400 hours, Respondent documented Patient P.A.'s confusion and behavioral changes which could have threatened Patient's P.A.'s safety. Respondent failed to intervene on behalf of Patient P.A. until 0100 hours on June 7, 2003 when Respondent gave the patient Risperdal 1 mg. Respondent failed to contact Patient P.A.'s physician to obtain further orders regarding Sedatives or testing to find out why the patient was becoming increasingly agitated when the patient did not respond to the ordered therapy Risperdal.
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> b. Between 0100 hours to 0200 hours on June 7, 2003,

Respondent asked a co-worker for anti-agitation medication instead of notifying the attending physician. Respondent then administered Diprivan IVP to Patient P.A. without a physician's order.

c. Respondent administered Diprivan IVP to Patient P.A. against hospital policies and procedures. Diprivan IVP can only be administered by a physician or an anesthesiologist to an intubated or mechanically ventilated patient.

d. Respondent administered Diprivan IVP to a patient who was neither intubated nor mechanically ventilated.

e. Respondent failed to initiate emergency procedures (calling a "Code Blue") when Patient P.A. was in cardio-pulmonary arrest, after she administered Diprivan which caused the premature and immediate death of the patient. Instead, Respondent directed/administered Narcan IV and Epinephrine IV to reverse the effects of Diprivan, neither of these drugs being effective as a narcotic antagonist.

f. Respondent failed to abide by practice standards regarding medication delivery. Respondent failed to give the patient appropriate reversal drugs, if any, and/or initiate emergency procedures in an attempt to provide appropriate care to the patient.

g. Respondent failed to adhere to standard infection control guidelines and regulations when she gave intravenous Diprivan, which was taken from another nurse's patient's intravenous medication, and directly infused it into Patient P.A.'s bloodstream through an IV cannula, thereby risking transmission of blood-borne infectious diseases from patient to patient, and from patient to nurse.

h. After Patient P.A. was pronounced at 0215 hours on June 7, 2003, Respondent immediately removed all the evidence and cleaned up Patient P.A.'s room before the police officers arrived to investigate the case.

17. Respondent is subject to disciplinary action pursuant to section 2671(a) (1) of the Code on the grounds of

unprofessional conduct as defined in California Code of Regulations, title 16, sections 1443 and 1443.5 in that on June 6, 2003, to June 7, 2003, while on-duty as a registered nurse at Providence Saint Joseph's Medical Center, Burbank, California, Respondent committed acts of incompetence as fully set forth in paragraphs 14 to 16 above.

18. Respondent is subject to disciplinary action pursuant to section 2761(a) of the Code in that from on and between June 6, 2003, to June 7, 2003, while on-duty as a registered nurse at Providence Saint Joseph's Medical Center, Burbank, California, Respondent committed acts of unprofessional conduct as fully set forth in paragraphs 14 to 16 above.

19. Respondent is subject to disciplinary action pursuant to section 2761(k) of the Code for the knowing failure to protect her patient by failing to follow infection control guidelines, in that from on June 6, 2003, to June 7, 2003, while on-duty as a registered nurse at Providence Saint Joseph's Medical Center, Burbank, California, Respondent gave intravenous Diprivan from another patient's intravenous medication, and directly infused the Diprivan into Patient P.A.'s bloodstream. The circumstances are as more fully set forth in paragraphs 14 to 16 above.

20. Respondent is subject to disciplinary action pursuant to Section 2761(d) of the Code, in that on June 6, 2003, to June 7, 2003, Respondent violated or attempted to violate, directly or indirectly the provisions of the Nursing Practice Act, as alleged in paragraphs 16 through 19 above.

...

26. Respondent has subjected her license to discipline pursuant to Business and Professions Code section 2750 for unprofessional conduct as defined in Business and Professions Code section 2761, subdivision (f), and in violation of Business and Professions Code section 490 in that Respondent was convicted of a crime substantially related to the qualifications, functions, and duties of a registered nurse.

Mitigation/Rehabilitation

21. Respondent has been a Registered Nurse for six years. She graduated from a two-year program at Los Angeles County-USC Medical Center and worked at the County Medical Center for approximately four years before being employed at Providence-St. Joseph's in Burbank. At Providence-St. Joseph's she worked only in the ICU. Her performance reviews at that hospital were always satisfactory or better.

22. Respondent submitted numerous letters attesting to her good moral character, and her compassion and dedication as a Registered Nurse. These included four letters from her parents, grandmother and siblings; five from co-workers and supervisors at her present place of employment; eleven letters from co-workers and supervisors at former places of employment; two from friends of many years; and two from persons who were in the past patients or family of patients under Respondent's care. The letters in support of Respondent are heart-felt and uniformly effusive in their praise for her many fine personal qualities and for her compassion and professional competence in her nursing work. Only one letter, however, from a friend/former co-worker, evidenced any knowledge of the matter for which Respondent faces discipline. Even that writer contributes no insight to the vast discrepancy between Respondent's actions, as set forth in Factual Findings 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18, and her reputation for high moral character and professional competence.

23. Because Respondent is not currently working as an R.N., the written statements submitted from her current employer and its staff as to her present level of competence pertain to skills other than nursing.

24. Within a few weeks of her crime, Respondent sought counseling from Jewish Family Service in Torrance, where she has been treated on a weekly basis for post-traumatic stress disorder and depression by Karen Tobias, Licensed Marriage and Family Therapist. Ms. Tobias believes that Respondent has matured over the last two and a half years, since the death of Patient P.A., and that Respondent has made excellent progress in addressing her reactions to stressful situations and her ability to respond appropriately. Ms. Tobias stated that Respondent's depression and anxiety have abated and that recently her therapy has focused on "life-balancing" skills. It is Ms. Tobias' professional opinion that Respondent is no longer unduly "spontaneously reactive," nor is Respondent still "overly responsible" as Ms. Tobias contends she was at the time of her crime. Tobias testified that Respondent expressed remorse for the death of patient P.A. during her counseling. Tobias opined that the actions of Respondent which caused the death of Patient P.A. were symptomatic of Respondent's failure to recognize her limits and her tendency to take on too much responsibility. Ms. Tobias' opinion was not persuasive as her opinion is inconsistent with Factual Findings 7, 9, 10, 11, 12, 13, 14, 15, 16, 17 and 18 which evidence Respondent's lack of responsibility, empathy and compassion; Respondent's willingness to put her own needs and comfort ahead of that of her patient and her employer; her disregard and indifference to professional standards and hospital procedures; and her deliberateness and calculation in attempting to evade responsibility for her actions.

25. The psychotherapy and counseling which Respondent has received since the time of her crime, as set forth in Factual Finding 24, does not constitute a rehabilitation or recovery program because it was undertaken to address Respondent's reaction to the consequence of her actions, rather than to affect and resolve the underlying problems which caused Respondent's actions.

26. Respondent contends that the psychological counseling by Ms. Tobias has given her insight that her treatment of Patient P.A. was an error in judgment which occurred because she was too emotionally involved, too compassionate and overly sensitive to the needs of her patients. Further, Respondent contends that the counseling has caused her to recognize that she needs more balance in her life. Respondent's insight on the causes and circumstances of her actions that caused the patient's death is superficial and self-serving and fails to include any considerations of the values, needs or expectations of others. Moreover, Respondent's beliefs as to the causes and circumstances underlying her actions on June 6 -7 are not persuasive in they are inconsistent with Factual Findings 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 and 19 which demonstrate Respondent's lack of compassion and sensitivity to her patient's needs, Respondent's lack of respect and vigilance for the trust placed in her by her employer and Respondent's determination that her self-interest supersedes the needs and trust of both her patient and her employer.

27. Respondent is current in her payments toward her fine, has completed her community service obligation and has to date complied with the terms of her probation. Her probation will terminate in November, 2009.

28. Since her crime, Respondent has completed more than 130 hours in on-line and home-study continuing education courses. These include "Medical Error Prevention: Patient Safety," "Ethical and Legal Issues in End of Life Care," "Pain and Symptom Management in End of Life Care," "Nursing Care At the End of Life," "Patient Advocacy,"and others.

29. If allowed to retain her R.N. license, Respondent plans to continue with her psychotherapy and to complete additional classes toward a Master's of Science Degree in Nursing.

Costs of Investigation and Prosecution

30. Pursuant to Business and Professions Code section 125.3, subdivision (a), Complainant has requested that Respondent be ordered to pay the reasonable costs of the investigation and enforcement of this case.

31. Complainant submitted a Certification of Costs of Investigation and Prosecution, documenting the time billed for this case by the Division of Investigation (DOI), Department of Consumer Affairs, assigned by the Board to investigate this case, and by the Department of Justice (DOJ), Office of the Attorney General. The Certification

documents actual costs of the investigation and prosecution, through January 13, 2006, not including presentation of evidence at the hearing, in the amount of $14,425.25. The Certification is supported by the following additional evidence:

(a) Declaration of DOI Investigator Broughton O'Keefe for fiscal year 2003/2004, establishing 23.75 hours work at a rate of $120 per hour, for a total investigation cost of $2,850. His activities were: (1) review and preparation of assignment; (2) contacting and interviewing victims, witnesses and the subject; (3) preparing and serving subpoenas; (4) preparing correspondence and/or declarations; (5) collecting, organizing and evaluating documentation and other physical evidence; (6) research; (7) travel to and from the locations necessary to conduct investigative activities; and (8) report preparation; and

(b) Declaration of Deputy Attorney General Linda L. Sun, documenting actual costs of the Office of Attorney General for fiscal years 2003/2004 2004/2005 and through February 2, 2006, of $11,662.75. These costs are based on time records and billing rates of attorneys, supervising attorneys and legal assistants for (1) case evaluation and assessment; (2) research; (3) pleading preparation; (4) client communication; (5) document preparation; (6) case management; (7) communication with other party; (8) pre-hearing conference; (9) trial preparation; and (10) witness-related preparation.

32. There was no evidence that any of the actual costs of investigation and enforcement were unnecessary or unreasonable.

33. Respondent contends that an order to pay the reasonable costs of investigation and enforcement would subject her to financial hardship. The evidence does not support Respondent's contention. Under *Zuckerman v. State Board of Chiropractic Examiners*, (2002) 29 Cal.App.4th 32, 45, the Board must consider the licensee's ability to make payment. Respondent is presently employed full-time and, except for the first few weeks after the death Patient P.A., she has been employed at all times that this case has been pending. Respondent nets approximately $3000 monthly; she supports no one but herself; and her employment is secure in that her present employer is well-satisfied with her performance. Respondent lives with her sister and shares all housing costs and related household expenses. Respondent's student loans are capped at $50 per month, and she has a modest monthly car payment. The monthly charge for the costs of her criminal probation is $50 per month. There is no civil judgment against Respondent for her actions toward Patient P.A., nor was she required to incur expenses to defend a civil action by the family of Patient P.A. or by the hospital. Her criminal plea resulted in an order of only $200 restitution and a fine of $2700, most of which has been paid. Respondent's significant monthly financial obligations are limited to debt incurred for legal counsel for defense of criminal prosecution and discipline of her license. Given an appropriate period of time in which to make monthly

payments against the total, Respondent has the ability to pay the reasonable costs of investigation and enforcement without enduring financial hardship.

LEGAL CONCLUSIONS

1. Cause exists to revoke Respondent's Registered Nursing license pursuant to section 2761, subdivision (a) (1), of the Business and Professions Code and in conjunction with California Code of Regulations, title 16, section 1442 in that on and between June 6, 2003, to June 7, 2003, she was grossly negligent, as set forth in Factual Findings 3, 5, 7, 10, 11, 12, 13 and 20.

2. Cause exists to revoke Respondent's Registered Nursing license pursuant to section 2671, subdivision (a)(1), of the Business and Professions Code on the grounds of unprofessional conduct as defined in California Code of Regulations, title 16, sections 1443 and 1443.5 in that on June 6, 2003, to June 7, 2003, while on-duty as a registered nurse at Providence Saint Joseph's Medical Center, Burbank, California, Respondent committed acts of incompetence, as set forth in Factual Findings 3, 5, 7, 10, 11, 12, 13 and 20.

3. Cause exists to revoke Respondent's Registered Nursing license pursuant to section 2761, subdivision (a), of the Business and Professions Code in that on and between June 6, 2003, to June 7, 2003, while on-duty as a registered nurse at Providence Saint Joseph's Medical Center, Burbank, California, Respondent committed acts of unprofessional conduct, as set forth in Factual Findings 3, 5, 7, 10, 11, 12, 13, 14 and 20.

4. Cause exists to revoke Respondent's Registered Nursing license pursuant to section 2761, subdivision (k), of the Business and Professions Code for the knowing failure to protect her patient by failing to follow infection control guidelines, in that from June 6, 2003, to June 7, 2003, while on-duty as a registered nurse at Providence Saint Joseph's Medical Center, Burbank, California, Respondent gave intravenous Diprivan from another patient's intravenous medication, and directly infused the Diprivan into Patient P.A.'s bloodstream, as set forth in Factual Findings 5, 7 and 20.

5. Cause exists to revoke Respondent's Registered Nursing license pursuant to section 2761, subdivision (d), of the Business and Professions Code, in that on June 6, 2003, to June 7, 2003, Respondent violated or attempted to violate the provisions of the Nursing Practice Act, as set forth in Factual Findings 5, 7 and 20.

6. Cause exists to revoke Respondent's Registered Nursing license pursuant to Business and Professions Code section 2750 for unprofessional conduct as defined in Business and Professions Code section 2761, subdivision (f), and in violation of Business and Professions Code section 490, in that Respondent was convicted of a crime substantially related to the qualifications, functions, and duties of a registered nurse, as set forth in Factual Findings 5, 7 and 20.

7. Pursuant to Business and Professions Code section 125.3, Complainant is entitled to recover reasonable costs of investigation and prosecution of this matter in the amount of $14,425.25, as set forth in Factual Findings 30, 31, 32 and 33.

8. The Board has adopted general standards for disciplinary action as follows in applicable part:

1. The recommended discipline for violations of Section 2761, subdivision (a) (1), incompetence or gross negligence, is revocation; the minimum discipline recommended is revocation stayed with three years probation.

2. The minimum recommended discipline for violations of Section 2761, subdivision (a) (2), conviction of practicing medicine without a license, is revocation stayed with three years probation.

3. The minimum recommended discipline for violations of Section 2761, subdivision (d), violating or abetting violation of any section of the Nursing Practice Act, revocation stayed with three years probation.

4. The recommended discipline for violations of Section 2761, subdivision (f), conviction of a offense substantially related to the qualifications, functions and duties of a registered nurse, is revocation.

5. The minimum discipline for violations of Section 2761, subdivision (k), knowingly failing to follow infection control guidelines, with potential or actual patient harm, is revocation.

6. The recommended discipline for patient neglect by failure to provide competent nursing care is revocation.

9. The Board has adopted factors to be considered in determining whether revocation, suspension or probation is to be imposed in a given case, as follows:

1. Nature and severity of the act, offense or crime under consideration.
2. Actual or potential harm to the public.
3. Actual or potential harm to any patient.
4. Prior disciplinary record.
5. Number and/or variety of current violations.
6. Mitigation evidence.
7. Rehabilitation evidence.
8. In case of a criminal conviction, compliance with conditions of sentence and/or court-ordered probation.
9. Overall criminal record.

10. Time passed since the act or offense occurred.
11. If applicable, evidence of expungment proceedings under Penal Code section 1203.4.

10. In this case, these factors do not support Respondent. Outweighing the fact that Respondent has no prior disciplinary or criminal record are (1) the aggravated character of her crime and the surrounding circumstances, as set forth in Factual Findings 5, 7, 9, 10, 11, 12, 13, 14, 15 and 16; (2) the actual – *ultimate* – harm to Patient P.A., as set forth in Factual Findings 5 and 7; (3) the harm to the public in the loss of trust and confidence in the hospital and in the nursing profession; and (4) the potential harm to the public in the event of similar subsequent conduct by Respondent. Then, too, are the facts that: (5) Respondent's crime constitutes multiple separate professional violations, including administering medication without a doctor's order; failure to follow hospital policies and procedures; and failure to adhere to infection control guidelines, which all, in and of themselves, constitute separate violations; (6) only two and a half years have passed since Respondent's acts; and (7) Respondent has completed only a little more than a year of her criminal probation which will not terminate until the end of 2009, as set forth in Factual Findings 5 and 27. The time which has elapsed since Respondent's crime, and since her conviction, is not sufficient to allow reliable judgments as to meaningful change in Respondent or as to her potential for subsequent reckless, unprofessional, or injurious conduct. Finally, the evidence of mitigation and rehabilitation is not persuasive, as set forth in Factual Findings 22, 23, 24, 25 and 26.

11. In her rehabilitation efforts, Respondent has completed numerous courses related to nursing, as set forth in Factual Finding 28. But evidence of continuing education and on-line and in-home course-work do not outweigh the evidence of Respondent's clinical incompetence and malfeasance, and continuing education evidence does not establish that Respondent is sufficiently competent or trustworthy to practice as a nurse.

12. There is a substantial risk to the public if Respondent is allowed to practice as a nurse, as set forth in Factual Findings 7, 9, 10, 11, 12, 13, 14, 15, 16, and 19.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

1. Registered Nursing License No. 575084, issued to Kelly Ann Miyasato, is revoked.

2. If and when Respondent's license is reinstated, she shall pay to the Board costs associated with its investigation and enforcement, pursuant to Business and Professions Code Section 125.3, in the amount of $14,425.25. Respondent shall be permitted to pay these costs in a payment plan approved by the Board. Nothing in this provision shall be construed

to prohibit the Board from reducing the amount of cost recovery upon reinstatement of the license.

DATED: March 14, 2006

CHRISTINE C. McCALL
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Supplemental Accusation Against: KELLY ANN MIYASATO 4404 Camero Avenue Los Angeles, CA 90027 Registered Nursing License No. 575084 Respondent.	Case No. 2004-287 OAH No. L2004060245 **FIRST SUPPLEMENTAL ACCUSATION**

Complainant alleges:

PARTIES

21. Ruth Ann Terry, M.P.H., R.N. (Complainant), brings this First Supplemental Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

22. On or about December 14, 2000, the Board issued Registered Nursing License No. 575084 to Kelly Ann Miyasato (Respondent). The license was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2006, unless renewed.

JURISDICTION

23. Paragraphs three (3) through twenty (20) of Accusation No. 2004-287 filed on April 9, 2004, are incorporated herein by reference as if fully set forth.

24. Business and Professions Code section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

. . . .

"(f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof."

25. Business and Professions Code section 490 provides, in pertinent part, that the Board may suspend or revoke a license when it finds that the licensee has been convicted of a crime, if the crime is substantially related to the qualifications, functions, or duties of that license.

SIXTH CAUSE FOR DISCIPLINE

(Conviction of a Substantially Related Crime)

26. Respondent has subjected her license to discipline pursuant to Business and Professions Code section 2750 for unprofessional conduct as defined in Business and Professions Code section 2761, subdivision (f), and in violation of Business and Professions Code section 490 in that Respondent was convicted of a crime substantially related to the qualifications, functions, and duties of a registered nurse for the following reasons:

a. On November 1, 2004, Respondent was convicted by the court on her plea of nolo contendere to violating Business and Professions Code section 2052, subdivision (a) (practicing medicine without a certificate - a felony), in the Superior Court of the State of California, County of Los Angeles, Northeast Judicial District, case number GA054672, entitled *The People of the State of California v. Kelly Ann Miyasato.*

b. The circumstances surrounding the conviction are that on or about June 7, 2003, Respondent injected the drug Diprivan into a patient by way of an intravenous push (IVP) through the patient's heparin lock without a physician's knowledge or order, as set forth more fully in paragraphs 14 through 16 of Accusation No. 2004-287. Hospital policies and procedures

allow Diprivan IVP to be administered only by a physician to an intubated or mechanically ventilated patient. The patient was neither intubated nor mechanically ventilated and died as a result of Respondent's actions.

c. Respondent's sentence includes five (5) years' formal probation, $200 in restitution, 350 hours of community service and a total fine of $2700.00.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nursing License No. 575084, issued to Kelly Ann Miyasato;

2. Ordering to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 11/24/05

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KELLY ANN MIYASATO 4404 Camero Avenue Los Angeles, CA 90027 Registered Nursing License No. 575084 Respondent.	Case No. **2004-286** **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about December 14, 2000, the Board issued Registered Nursing License No. 575084 to Kelly Ann Miyasato (Respondent). The license was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2004, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 118, subdivision (b), of the Code provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . . .

(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it.

. . . .

"(k) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of blood-borne infectious diseases from licensed or certified nurse to patient, from patient to patient, and from patient to licensed or certified nurse. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Health Services developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, guidelines, and regulations pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300), Division 5, Labor Code) for preventing the transmission of HIV, hepatitis B, and other blood-borne pathogens in health care settings. As necessary, the board shall consult with the Medical Board of California, the Board of Podiatric Medicine, the Dental Board of California, and the Board of Vocational Nursing and Psychiatric Technicians, to encourage appropriate consistency in the implementation of this subdivision. "The board shall seek to ensure that licentiates and others regulated by the board are informed of the responsibility of licentiates to minimize the risk of transmission of blood-borne infectious diseases from health care provider to patient, from patient to patient, and from patient to health care provider, and of the most recent scientifically recognized safeguards for minimizing the risks of transmission."

8. Section 2725 of the Code states:

. . . .

"(b) The practice of nursing within the meaning of this chapter [the Nursing Practice Act] means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:

. . . .

"(2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment,

disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code."

9. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

10. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5"

11. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

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"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUG DESCRIPTION

13. "Diprivan [Propofol]" is a rapid acting intravenous anesthetic agent, used for the induction and maintenance of anesthesia or sedation. According to the manufacturer, hypnosis and apnea occurs rapidly usually within 40 seconds, and "Propofol should only be administered to intubated, mechanically ventilated, adult patients in the Intensive Care Unit (ICU) to provide continuous sedation and control of stress responses. In this setting, Propofol should be administered only by persons trained in general anesthesia or critical care medicine. . .Strict aseptic techniques must always be maintained during handling as Propofol is a single-use parenteral product and contains no antimicrobial preservatives."

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BACKGROUND

14. On May 20, 2003, an 80-year-old patient (Patient P.A.) was admitted to Providence Saint Joseph's Medical Center, Burbank, California, complaining of worsening weakness, weight loss and poor appetite. On June 4, 2003, a bone marrow biopsy revealed multiple Myeloma. Due to the patient's additional health problems, age and extent of plasma cells in his bone marrow, no treatment was given for the Myeloma. Accordingly, the family desired no aggressive treatment options and a "No Code Blue," which meant in the event the patient has a cardio-pulmonary arrest, no aggressive resuscitative measures should be initiated.

15. From on about June 6, 2003 to June 7, 2003, while working a 12-hour shift from 1900 hours to 0700 hours, Respondent was assigned to care for Patient P.A. in the ICU at Providence Saint Joseph's Medical Center. At about 1900 hours, Respondent reported that Patient P.A. was awake, alert and restless with stable vital signs and oxygen saturation. According to the day shift nurse's notes, she indicated that Patient P.A.'s level of consciousness and behavior varied from awake, agitated, confused and combative to sleeping. Respondent documented a similar assessment from 1900 hours to 0100 hours. At about 0100 hours, Respondent medicated Patient P.A. with the physician-ordered Risperdal 1 mg tablet for agitation. When Patient P.A. continued to be agitated, Respondent asked a co-worker, Amy Brunner, RN, if there was a drug available to be given to Patient P.A. for agitation. RN Brunner stated there were two patients in the ICU who were receiving Diprivan. RN Brunner then went and withdrew approximately 4 to 5 ccs of Diprivan into a syringe from another nurse's patient's running intravenous (IV) tube and left it for RN Miyasato to be administered intravenous push (IVP) to Patient P.A. At about 0205 hours, Respondent took the Diprivan and injected approximately 4 ccs Intravenous Push (IVP)[1] through Patient P.A.'s heparin lock. Patient P.A. was not intubated or ventilated before or after the Diprivan administration. There was no physician's order for Diprivan for Patient P.A.. Immediately after the Diprivan administration,

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1. The 4ccs of Diprivan IVP would be equivalent to 40 mg of Diprivan, which is the general anesthesia induction dose. Patients receiving this dose would require assistance in maintaining a patent airway and positive ventilation.

Patient P.A.'s oxygen saturation and heart rate started to deteriorate. Respondent asked for help and in an attempt to reverse the effects of Diprivan, she gave Patient P.A. oxygen, Narcan IV and Epinephrine IV. Patient P.A. was pronounced dead at 0215 hours on June 7, 2003.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

16. Respondent is subject to disciplinary action pursuant to section 2761(a)(1) of the Code and in conjunction with Code of Regulations, title 16, section 1442 in that on and between June 6, 2003, to June 7, 2003, she was grossly negligent as follows:

a. On June 6, 2003 at about 2000 hours, 2200 hours and 2400 hours, Respondent documented Patient P.A.'s confusion and behavioral changes which could have threatened Patient's P.A.'s safety. Respondent failed to intervene on behalf of Patient P.A. until 0100 hours on June 7, 2003 when Respondent gave the patient Risperdal 1 mg. Respondent failed to contact Patient P.A.'s physician to obtain further orders regarding sedatives or testing to find out why the patient was becoming increasingly agitated when the patient did not respond to the ordered therapy Risperdal.

b. Between 0100 hours to 0200 hours on June 7, 2003, Respondent asked a co-worker for anti-agitation medication instead of notifying the attending physician. Respondent then administered Diprivan IVP to Patient P.A. without a physician's order.

c. Respondent administered Diprivan IVP to Patient P.A. against hospital policies and procedures. Diprivan IVP can only be administered by a physician or an anesthesiologist to an intubated or mechanically ventilated patient.

d. Respondent administered Diprivan IVP to a patient who was neither intubated nor mechanically ventilated.

e. Respondent failed to initiate emergency procedures (calling a "Code Blue") when Patient P.A. was in cardio-pulmonary arrest, after she administered Diprivan which caused the premature and immediate death of the patient. Instead, Respondent directed/administered Narcan IV and Epinephrine IV to reverse the effects of Diprivan, neither of these drugs being effective as a narcotic antagonist.

f. Respondent failed to abide by practice standards regarding medication delivery. Respondent failed to give the patient appropriate reversal drugs, if any, and/or initiate emergency procedures in an attempt to provide appropriate care to the patient.

g. Respondent failed to adhere to standard infection control guidelines and regulations when she gave intravenous Diprivan, which was taken from another nurse's patient's intravenous medication, and directly infused it into Patient P.A.'s bloodstream through an IV cannula, thereby risking transmission of blood-borne infectious diseases from patient to patient, and from patient to nurse.

h. After Patient P.A. was pronounced at 0215 hours on June 7, 2003, Respondent immediately removed all the evidence and cleaned up Patient P.A.'s room before the police officers arrived to investigate the case.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

17. Respondent is subject to disciplinary action pursuant to section 2671(a)(1) of the Code on the grounds of unprofessional conduct as defined in California Code of Regulations, title 16, sections 1443 and 1443.5 in that on June 6, 2003, to June 7, 2003, while on-duty as a registered nurse at Providence Saint Joseph's Medical Center, Burbank, California, Respondent committed acts of incompetence as fully set forth in paragraphs 14 to 16 above.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

18. Respondent is subject to disciplinary action pursuant to section 2761(a) of the Code in that from on and between June 6, 2003, to June 7, 2003, while on-duty as a registered nurse at Providence Saint Joseph's Medical Center, Burbank, California, Respondent committed acts of unprofessional conduct as fully set forth in paragraphs 14 to 16 above.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Follow Infection Control Guidelines)

19. Respondent is subject to disciplinary action pursuant to section 2761(k) of the Code for the knowing failure to protect her patient by failing to follow infection control

guidelines, in that from on June 6, 2003, to June 7, 2003, while on-duty as a registered nurse at Providence Saint Joseph's Medical Center, Burbank, California, Respondent gave intravenous Diprivan from another patient's intravenous medication, and directly infused the Diprivan into Patient P.A.'s bloodstream. The circumstances are as more fully set forth in paragraphs 14 to 16 above.

FIFTH CAUSE FOR DISCIPLINE

(Violation of the Nursing Practice Act)

20. Respondent is subject to disciplinary action pursuant to section 2761(d) of the Code, in that on June 6, 2003, to June 7, 2003, Respondent violated or attempted to violate, directly or indirectly the provisions of the Nursing Practice Act, as alleged in paragraphs 16 through 19 above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nursing License No. 575084, issued to Kelly Ann Miyasato;

2. Ordering Kelly Ann Miyasato to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 4/9/04

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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